2008 Report to the Law Enforcement and Criminal Justice Interim Committee From the State Emergency Medical Services Committee As Required by 26-8a-103 (4)

Respectfully Submitted for Presentation at the November Interim Committee Meeting

Introduction

1. The Utah Emergency Medical Services System Act (Chapter 8a) requires the statutory Emergency Medical Services (EMS) Committee to submit an annual report each November to the Law Enforcement and Criminal Justice Interim Committee. The highest priorities are still cost, quality and access to EMS regarding the development of a comprehensive and integrated state EMS system. As last year's report focused on the following six issues, 1) appropriate providers for emergency medical services; 2) funding priorities and recommended sources; 3) closest responder recommendations; 4) centralized dispatch; 5) duplication of services and taxing consequences; and 6) recommendations and suggested legislation, this years report will also address them in an effort to improve the statewide Emergency Medical Services system.

1. Appropriate Providers for Emergency Medical Services

Within the statewide EMS System, there are a total of 176 licensed and designated provider agencies serving every area of the state. The agencies are categorized as follow:

2. 123 Licensed ground ambulance and paramedic rescue agencies, and
3. 53 Designated quick response units providing various levels of pre-hospital care.

Resource Hospitals and Designated Trauma Centers: Within the statewide EMS system, the EMS Committee has designated all acute care hospitals and the VA hospital as resource hospitals. The 43 designated resource hospitals are committed to providing on-line medical direction and direct voice communications to EMS providers. A survey to assess the trauma capabilities is being conducted in the last quarter of 2008. Of the 43 Utah hospitals, nine have voluntarily met the extensive criteria required to be designated as trauma centers by the Department of Health. They are:

1.	Intermountain Medical Center	Level I
2.	Primary Children's Medical Center	Level I
3.	University of Utah Hospital	Level I
4.	McKay Dee Hospital	Level II
5.	Ogden Regional Medical Center	Level II
6.	Logan Regional Hospital	Level III
7.	Dixie Regional Medical Center	Level III
8.	Bear River Valley Hospital	Level IV
9.	Uintah Basin Medial Center	Level IV

In addition to the above facilities, a focused visit to Utah Valley Regional Medical Center has been scheduled for November 12, 2008, to verify compliance as a Level II trauma center, and a visit has

been scheduled for December 8, 2008, with Allen Memorial Hospital in Moab to verify compliance as a Level IV trauma center. The Department of Health continues to work toward designation of the following rural hospitals: Sanpete Valley Hospital, Fillmore Medical Center, and Delta Medical Center. Interest in becoming designated as Level III trauma centers has been expressed by Timpanogos Regional Medical Center in Orem and Mountain View Hospital in Payson.

Hospitals Participating in the Hospital Preparedness Program: In 2002 the Health Resource and Services Administration (HRSA) began a grant program designed to help hospitals and other healthcare entities to become more prepared for biological terrorism and other disasters. This grant has been managed within the Bureau in partnership with the Utah Hospital Association, Community Health Clinics of Utah, Department of Human Services, Division of Information Technology, and other state/local agencies and partners. To date the program has grown to a total of 121 health care facilities. These facilities are categorized as follow:

Trauma Centers	9 (Includes 1 Pediatric Hospital)
Acute Care Hospitals	34
Pediatric Hospitals	1
Long Term Care/Rehab Hospitals	55
Psychiatric Hospitals/Facilities	2
Community Health Clinics	14
Tribal Health Systems	4

EMS Personnel: The EMS personnel affiliated with these licensed agencies are either part-time paid or full-time paid employees. There are six levels of certification for EMS personnel: Emergency Medical Dispatch, EMT-Basic, EMT-Intermediate, EMT-Intermediate Advanced, and EMT-Paramedic. In July 2009 a sixth level, Emergency Medical Responder was added. Each level has a specific scope of practice and hours of training:

EMT-Basic	120 hours
EMT-Intermediate	54 hours which include IV therapy, intubation and limited medications
EMT-Intermediate Advanced	600 hours (approximately) competency based
EMT-Paramedic	1260 hours
EMD	24 hours
Emergency Medical Responder	66 hours (added in July 2009)

Service Levels: An applicant for licensure or designation can apply to provide any of the following levels of service. The list also includes the current number of licensed and designated providers within Utah at each level of service.

Transporting licensures:

Basic Ambulance	10
Intermediate Ambulance	69
Intermediate Advanced Ambulance	2
Paramedic Ambulance	20
Air Ambulance	11

Non-transporting licensures:	
Paramedic Rescue	22
Non-transporting designations:	
Basic Quick Response Unit	34
Intermediate Quick Response Unit	19
EMS Dispatch Center	52

Service Level Selection: The licensure level of a pre-hospital EMS service provided by an ambulance is determined by local officials of the community being served. According to the Utah EMS Systems Act, 26-8a-403 (7) "The role of local governments in the licensing of ground ambulance and paramedic providers that serve areas also served by the local governments is important. The Legislature strongly encourages local governments to establish cost, quality and access goals for the ground and paramedic services that serve their areas."

New Licensed EMS Providers: The following agencies received a new license this year:

Unified Fire Authority	Paramedic Ground Ambulance
Bluffdale Fire Department	Paramedic Ground Ambulance
South Jordan Fire Department	Paramedic Ground Ambulance
Murray City Fire Department	Paramedic Ground Ambulance

The following were re-licensed this year:

Juab County Ambulance	Intermediate Ground Ambulance
Dixie Ambulance Service	Paramedic Rescue
Dixie Ambulance Service, Inc.	Intermediate Ground Ambulance
Wayne County Ambulance	Intermediate Ground Ambulance
WVC Fire Department/SLCo Fire Dept	Paramedic Rescue
Ephraim City/Ephraim Ambulance Association	Intermediate Ground Ambulance
Sevier County Ambulance	Intermediate Ground Ambulance
Wendover Ambulance	Intermediate Ground Ambulance
Santaquin City Ambulance	Intermediate Ground Ambulance
Piute County Ambulance	Intermediate Ground Ambulance
South Jordan Fire Department	Paramedic Ground Ambulance
Dixie Ambulance Service, Inc.	Paramedic Ground Ambulance
Farmington Fire Department	Intermediate Ground Ambulance
Murray City Fire	Paramedic Rescue
Sandy City Fire Department	Paramedic Ground Ambulance

The following are due to re-license by December 2008:

Pleasant Grove Ambulance	Paramedic Rescue
Rich County Ambulance	Intermediate Ground Ambulance
Brigham City Ambulance	Intermediate Ground Ambulance

Levan Town Ambulance	Intermediate Ground Ambulance
Canyon Fuel Company SUFCO, LLC	Basic Ground Ambulance
Eagle Mountain Fire Department	Paramedic Rescue
North Fork Fire Department	Intermediate Ground Ambulance

EMS Care Consistency: Whether in rural Utah or on the Wasatch Front, EMS personnel meet the same training and certification standards and stand ready to care for victims of injury or illness. Licensed ambulance providers throughout the state are required to have the same personnel, equipment, and operational standards. Through automatic aid agreements and local disaster plans, these licensed ambulance providers are in a constant state of readiness to serve the public. They are becoming more skilled and prepared to deal with weapons of mass destruction and mass casualties from natural and human caused disasters.

Recruitment and Retention: Some rural services are having difficulty in recruiting and retaining personnel sufficient to maintain services. Continuous turnover of staff decreases the skill level of the service. The problem is most prominent in sub-frontier counties. The common problem is the inability to provide pay at a level to prevent migration to the larger markets. While lack of revenue due to low call volume and low-income communities will always be a problem, many of the rural agencies are contributing to the problem through unwillingness to charge for services at levels allowed by law or even to charge at all. This is further limiting the revenue available to retain personnel. Several of the hardest hit areas experience a surge in calls during their respective tourist season, yet these counties or cities have not enacted taxation of the tourist population to support the infrastructure needs. The Bureau of EMS is working with the local agencies to encourage active funding of EMS.

Background Criminal Investigation Process: On July 1, 2007, the EMS Systems Act changed to give the Bureau of EMS access to juvenile records of anyone 27 or younger, and anyone with a previous misdemeanor or felony conviction. This is important if the offense involved sexual or drug abuse or extreme violence, so that vulnerable members of the public are better protected from individuals with past criminal records.

EMS Strike Teams: On January 6, 2008 a partial EMS Strike team was deployed to assist San Juan County EMS during the bus crash incident. There were four EMS Strike team members along with one Bureau staff that responded. The team assisted San Juan County EMS for three days. During these three days, the strike team members transported seven bus crash victims to airports where these patients were then flown to critical care hospitals. They also responded on numerous 911 calls allowing 51 of the responders to attended the Critical Incident Stress Management debriefing held in Bluff.

On July 4, 2008, an EMS Strike Team and Pediatric trailer was requested to stand by at the Stadium of Fire. There were also two Bureau staff members on Standby.

On August 16, 2008, EMS and Pediatric Strike Teams assisted in a National Disaster Medical Systems (NDMS) exercise held at the Air National Guard. These teams assisted the Federal Coordinating Center (FCC) so well that the FCC modified their plan to include the teams to take a more active role during an NDMS incident.

Pediatric Strike Teams: During the previous fiscal year, the Bureau recruited for and formed four pediatric-specific strike teams. Each team consists of a mix of nine pediatric medical personnel at the Physician, Nurse Practitioner, Registered Nurse, Paramedic, EMT-Intermediate Advanced and EMT-Intermediate levels. These teams can be deployed during a disaster in coordination with the EMS strike teams. To date, 900 hours of disaster specific training has been provided to team members. Additional training is planned for team members next year. The intended application of the pediatric strike teams would be to provide medical care to pediatric patients at a disaster site, augment hospital staffing, triage center staffing, or casualty collection points. There are two equipment trailers the teams utilize; each contains medical supplies and equipment to care for up to 100 pediatric patients. Facilities could request response of the trailer to assist with supplies needed to care for pediatric patients. Once deployed, pediatric strike team members would rely on the current EMS strike team's support trailer to sustain the team through a field deployment for 72 hours, with only food and water needed to extend the deployment.

Critical Incident Stress Management Team: The Bureau has continued to provide funding and direction for the use of the CISM Team. Currently the Team consists of seven regions throughout the State providing 25 mental health professionals and 110 peer volunteers. The Team provided 35 debriefings, 15 education trainings, and several public outreach efforts this past fiscal year. Debriefings and trainings are provided at no cost to first responders and spouses from agencies including law enforcement, fire, EMS, dispatch centers, hospitals, and auxiliary agencies involved in traumatic events.

EMS POLARIS System: In 2004, the National EMS Information System (NEMSIS) data standard was published, and Utah was one of 52 states and territories to commit to adopt the standard in its prehospital data collection system. The Bureau created the Prehospital On-Line Active Reporting Information System (POLARIS) to replace the existing 20-year-old data collection system and implement the NEMSIS standard. POLARIS went live in September 2006. As of October 8, 2008, 62% of EMS agencies are reporting data to the Bureau using the new standard compared to 48% one year ago. In September 2008, the 100,000th patient care report was submitted in POLARIS. During 2008, R426-7 was revised to make the NEMSIS standard mandatory; multiple data entry enhancements were completed in POLARIS; and data analysis features were expanded. In December 2007, Utah became one of the first ten states to begin sending data to the National EMS Database.

2. Funding Priorities and Recommended Sources

EMS Grants Program: In 1986, the Legislature created a funding mechanism to establish an EMS Grants program to help offset the lack of tax-based funding and federal aid for the improvement of the EMS system throughout the state. This program is funded by a dedicated source (criminal fines and forfeitures) which established grants for the improvement of the statewide emergency medical services system. The Department of Health receives an amount equal to 14% of the total amount accumulated through the criminal fines and forfeiture process.

By statute, the EMS grants program was divided into fund accounts. The Department may use funds for statewide staff support, administrative expenses, other department administrative costs under this chapter, and trauma system development. Fifteen percent is dedicated to funding high school emergency medical training programs. Of the remaining funds, 42.5% is allocated for per capita

grants, and 42.5% for competitive grants to local EMS entities.

In FY 2008, the EMS program received $2.7 million for this program. This amount allowed the EMS Committee to distribute $1,100,000 through competitive grants, and $1,100,000 through per capita grants for a total of $2,200,000.

The Per Capita grants are determined by a point system. Each EMT is given a number of points for their level of certification:

Basic	2 points
Intermediate	3 points
Intermediate Advanced	3 points
Paramedic	4 points
EMD (dispatcher)	1 point

Certified personnel receive per capita funding for only one agency per county. Agencies that cover multiple counties receive points for their personnel from the county where the certified person lives.

The Department contracted with the State Office of Education for the high school training program. "What to Do When Every Minute Counts" was taught to over 12,000 local high school students. A workbook for students and power point presentations for the teachers have been developed to use during their courses. The State Office of Education is also working with an EMS Coalition to have local EMS agencies provide the CPR portion of the courses.

During FY09, the Bureau had allocated $1,299,000 in competitive grants and $1,000,000 in per capita grants. During August expenditures exceeded what was anticipated, and the carryover from FY08 was less than expected. The Bureau asked the Grants Subcommittee and the EMS Committee to request a 20% reduction for all grants due to the shortages. The new revised amounts for competitive grants were $1,000,000 and per capita grant $900,000.

After the Legislature met in a special session in October, an additional $1,000,000 of the Restricted EMS Grant funds was taken. The Grants Subcommittee met again and the EMS Committee made the decision to cut all grants another 50%. The Competitive and Per Capita grants were then allocated at $600,000 each. This was anticipated to be a one-time cut.

Emergency Medical Services for Children Outreach Initiatives: One of the goals of the National Emergency Medical Services for Children (EMSC) program is to establish permanence of EMSC in each State's EMS System. The National EMSC and HRSA program recommend that the EMSC Coordinator function as an integral staff member of the EMSC program with the state office of EMS. An EMSC Program Manager position that is supported by non-federal funds is an indication that the EMSC program in the state is being sustained over the long term and achieving the desired outcome and providing access to healthcare for children. Trauma Program funding was secured to support the EMSC Program Manager position in Utah. Another goal of the National EMSC program is the existence of hospital-based written pediatric interfacility transfer agreement and guidelines. Utah met the 2011 target for this goal. Ninety percent of Utah hospitals now have written pediatric inter-facility transfer agreements and guidelines in place. The need for pediatric

pre-hospital education is significant for EMS providers due to the limited funding, time, and availability of pediatric expertise at the local level. During this past funding cycle, EMSC provided pediatric medical emergency training to 1,624 Utah EMS providers.

Rate Adjustments: The Department of Health conducted a study of the ambulance base rates. The study evaluated the current base rates and assessed the provider revenues needed to achieve an adequate return. The Department authorized a 6.1% maximum base rate increase order which took effect on July 1, 2008. This increase mirrored the statistical indices as required by rule to compensate for inflation, labor costs, and fuel costs. The Emergency Response and Night surcharges were eliminated to simplify billing. The only surcharge a consumer could receive is for off-road mileage (after the first ten miles). The monies lost from the Emergency Response and Night Surcharges were then factored into the new base rate. Additionally, the predetermined threshold for the fuel fluctuation fee was adjusted to allow for more immediate increases in fuel prices

3. Closest Responder Recommendations

The EMS law clearly identifies that each provider be licensed for an exclusive geographical service area with aid agreements in place to allow for response when they are not available. This system takes into consideration at the time of licensure and re-licensure that the most appropriate responder is licensed for the exclusive geographical area. There is no consideration in the statute or rules that allow for the current location of a responder to be the determining factor.

4. Dispatch Center Designation

A Dispatch Center Task Force recommended to the Operations Subcommittee three levels of dispatch center designation exist: basic, intermediate, and advanced was tabled with a request that the Bureau of EMS conduct a survey as part of the annual dispatch center quality review to determine if there is a genuine need for various levels of dispatch center designations.

The concerns expressed by the Operations Subcommittee focused on the fact that in a basic level dispatch center, a 911 call taker is not likely to be a certified Emergency Medical Dispatcher and therefore would not have the ability to give the caller lifesaving pre-arrival instructions. The survey and re-designation process for all EMS dispatch centers is nearing completion. A final report will be presented to the Operations Subcommittee at the December meeting.

5. Duplication of Services and Taxing Consequences

Since the law requires exclusive geographic service areas and does not allow overlapping, there is no duplication of services in the emergency response area, and therefore, no taxing consequence. Where there is a “Request for Proposal” license there are always two providers for the same area, one providing 911 services and one providing non-911 services. This is not duplication because the 911 provider does not provide non-911 services and vice versa.

6. Recommended and Suggested Legislation

As the Utah EMS system evolved and the licensed providers' desire for expansion has stabilized, there is no suggested legislation. Over the past year, EMS providers have embraced the language in the law 26-8a-408 criteria for determining public convenience and necessity, "The role of local governments in the licensing of ground ambulance and paramedic providers that serve areas also served by the local governments is important. The Legislature strongly encourages local governments to establish cost, quality and access goals for ground ambulance and paramedic services that serve their areas."

Conclusion

The State EMS Committee continues to believe that essential stable funding sources be implemented to assist all local EMS providers in managing the increasing demands of the citizens. This will help EMS providers who are always in a constant state of readiness to meet the needs of patients regardless of their ability to pay. As the EMS Committee considers decisions affecting EMS providers and the public, cost, quality, and access will continue to be the major considerations.

During the past few months, the Bureau of Emergency Medical Services has completed a merging of the two preparedness functions and EMS into the EMS and Preparedness Bureau. Over the past few years, a strong statewide effort has been made to educate and equip EMS providers and hospitals with the necessary tools to respond to natural or human caused disasters. With an ever changing world around us and the unknown status of terrorism or disasters, security and disaster preparedness has recognized EMS providers as first responders and hospitals as first receivers. This clearly identifies them as a significant link between the victims of injury or illness and the healthcare delivery system. Additional efforts will be made with EMS providers and hospitals to encourage them to continue to work closely with local law enforcement, health departments, and community leaders to hold exercises, integrate, and update their disaster response plans including surge capacity and contingency plans.

Utah has an EMS system with oversight and responsibility for delivery of emergency medical services from the originating 911 call for help to the delivery of the patient to the appropriate patient receiving facility. This system is enhanced and the safety of the users of the system improved as all parties work together in a unified approach to problems, thus assuring the public of a safe and efficient system. The EMS Committee plays a vital role in the oversight of the system and is proud of the working relationship between the Bureau of EMS and Preparedness, all providers, and the citizens of the state.

Respectfully,

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